

5696

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN lb <b>2 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DOROTHY M. ABELL</b>		4. DATE OF DEATH Month Day Year <b>MAY 9 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1916</b>
9. AGE (In years last birthday) <b>43</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mark Milburn</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Adams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Squamous Cell Carcinoma of Endocervix</b> DUE TO <b>Metastatic</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 MOS.</b> <b>2 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20b. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County) (State)	
21. I certify that I attended the deceased from <b>May 58</b> to <b>May 9, 1960</b> that I last saw the deceased alive on <b>May 9, 1960</b> and that death occurred at <b>12:55 PM EST</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. PARRAN JARBOE M.D.</b>		DATE SIGNED <b>5-9-60</b>	
PHYSICIAN'S NAME (Type) <b>J. PARRAN JARBOE M.D.</b>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 11, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>St Marys City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The HUNTT Funeral Home, Waldorf, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 17 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10/1/53

LETTER NO. 10

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

05672  
Reg. Dist. No.

5697

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Nanjemoy</u>		c. LENGTH OF STAY IN 1b <u>lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. STREET ADDRESS <u>Smith Point Road</u>	
3. NAME OF DECEASED (Type or print) <u>Bastain</u> First <u>Eddie</u> Middle <u>BASTAIN</u> Last		4. DATE OF DEATH <u>May</u> Month <u>21</u> Day <u>1960</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-14-1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Chas Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Getien Bastian</u>		14. MOTHER'S MAIDEN NAME <u>Dian Mudd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>Horace Bastian Benjamin</u> Address <u>2nd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertensive Cardio-vascular disease</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>19</u> to <u>21 May</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>21 May</u> , 19 <u>60</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur B. Woody</u> M.D.		ADDRESS (Street, city or town, state) <u>JARWOOD CLINIC</u> DATE SIGNED <u>21 May 60</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR B. WOODY</u>		<u>LA PLATA, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5/23/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nanjemoy Baptist</u>	22d. LOCATION (City, town, or county) (State) <u>Nanjemoy Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Mc LaPlata</u> ADDRESS <u>2nd</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>MAY 24 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles E. Frank</u>

100

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STATE OF NEW YORK  
IN SENATE  
JANUARY 10, 1900

REPORT  
OF THE  
COMMISSIONER OF THE  
LAND OFFICE  
IN RESPONSE TO A  
RESOLUTION PASSED  
BY THE SENATE  
MAY 1, 1899

ALBANY:  
J.B. LEECH, PRINTERS  
1899

THE STATE OF NEW YORK  
OFFICE OF THE COMMISSIONER OF THE LAND OFFICE  
ALBANY, N. Y.

ALBANY, N. Y.  
JANUARY 10, 1900

## CERTIFICATE OF DEATH

05673  
Reg. Dist. No.

5698

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b <b>X Pisgah</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicans Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BOWIE, ELIZABETH R.</b>		4. DATE OF DEATH Month <b>5-</b> Day <b>9-</b> Year <b>66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W-WS</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-21-83</b>
9. AGE (In years last birthday) yrs. <b>76</b>		10. UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.	11. UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Charles County, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Lemuel Welch</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. William T. Bowie, Pisgah, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> DUE TO <b>170x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the Cervix</b> DUE TO <b>10x</b> (c) <b>Carcinoma of the Breast</b> <b>10x</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-9-60</b> 19 to <b>5-9-60</b> 19, that I last saw the deceased alive on <b>5-9-60</b> 19, and that death occurred at <b>1040 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James E. Ann</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>5-10-60</b>	
PHYSICIAN'S NAME (Type) <b>JAMES E. ANN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/12/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Nazerine Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pisgah, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arehart, Inc.</b> ADDRESS <b>Arehart Funeral Home, Inc. - La Plata, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 16 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>William L. Thomas</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

1907

DEPT. OF AGRICULTURE

1907

1907





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05674

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Newport</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Newport</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>FRANK</i> First <i>A</i> Middle <i>BOWLING</i> Last		4. DATE OF DEATH Month <i>5</i> Day <i>14</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-17-93</i>
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Bowling Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Nonnie Higgs</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>217-36-8362</i>	
17. INFORMANT <i>Ruth Redwood Leplata Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Occlusion</i> Conditions, if any, which gave rise to immediate cause (b) <i>Gen Art Sclerosis</i> (c) <i>1955</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>5-14-60</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. Edelen</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/18/1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Methodist</i>		22d. LOCATION (City, town, or county) (State) <i>Denmar Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur L. Kline</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>MAY 20 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

DATE SIGNED *5-16-60*

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED EXCEPT WHERE SHOWN OTHERWISE



5700

## CERTIFICATE OF DEATH

Reg. Dist. No.

PLACE OF DEATH  
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO. (If yes, give year or dates of service)

INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

434.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH  
48 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☐20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m.  
p. m.20d. INJURY OCCURRED  
While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 5-20, 1960, to 5-22, 1960, that I last saw the deceased alive on 5-22, 1960, and that death occurred at 8:20 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE

F. M. JOHNSON M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

LA PLATA, Md. 5-22-60

PHYSICIAN'S NAME (Type)

F. M. JOHNSON M.D.

22a. BURIAL CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Frazier's Funeral Home - 389-R. 2 Ave. N.W.

DATE MAY 24 '60

C. L. S. Knead

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(1)

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5701

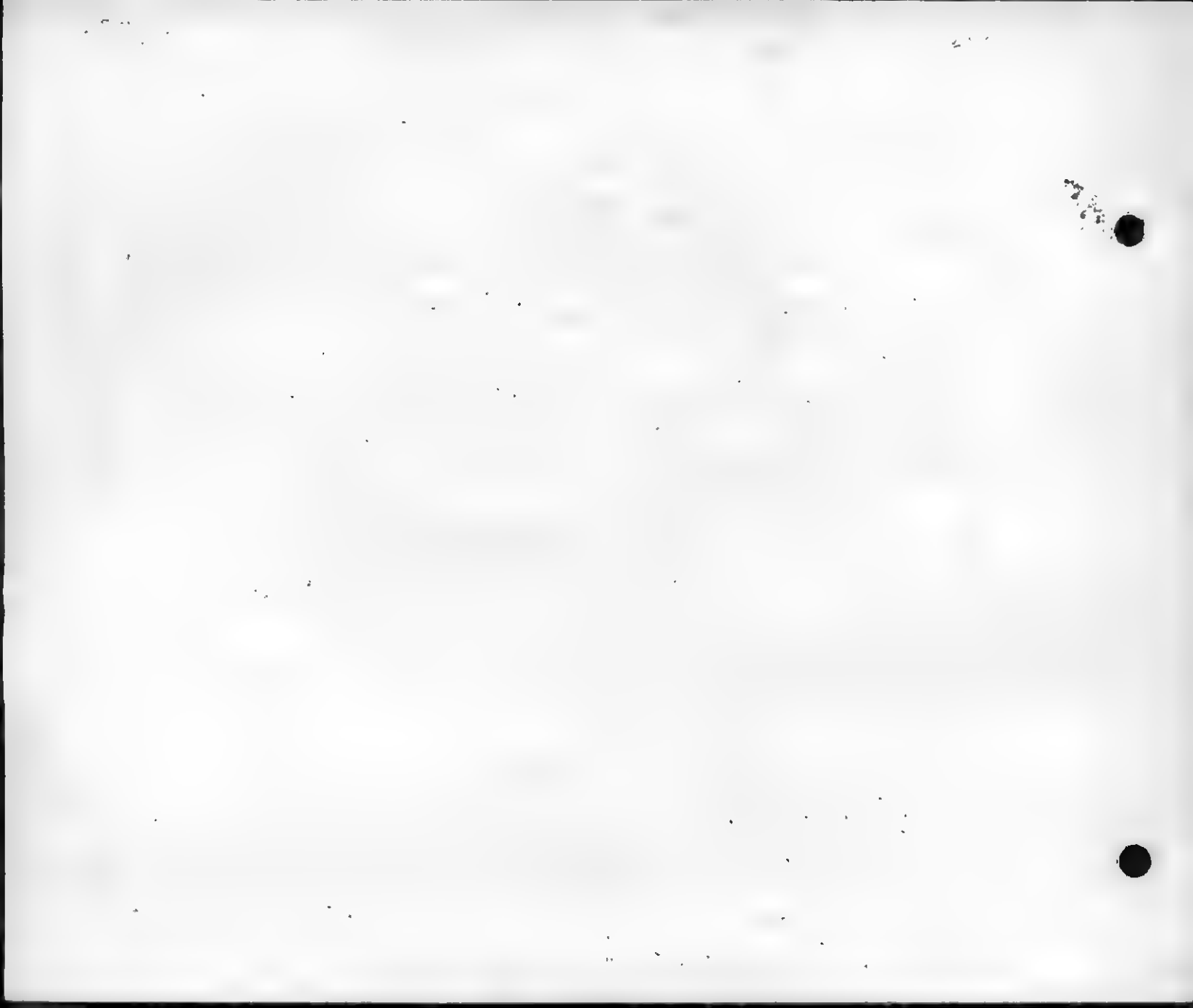
## CERTIFICATE OF DEATH

Reg. Dist. No. 05676

1 PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN lb <b>13 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newburg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ellen</b> Middle <b>Machel</b> Last <b>Dorsey</b>				4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1960</b>	
9. AGE (In years last birthday) <b>13</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>John C. Dorsey</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Ellen Edelen</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT <b>Mary E. Dorsey, Newburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malnutrition</b> DUE TO <b>157.3</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anencephalus</b> DUE TO <b>congenital anomaly</b> (c) <b>congenital anomaly</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>5-24-60</b>							
ACTUAL SIGNATURE <b>Arthur Woody</b> M.D.				PHYSICIAN'S NAME (Type) <b>ARTHUR WOODY</b>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-24-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Marys</b>		22d. LOCATION (City, town, or county) (State) <b>Bryantown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The HUNT Funeral Home, Waldorf, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. S. K. K.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2066171XVS



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

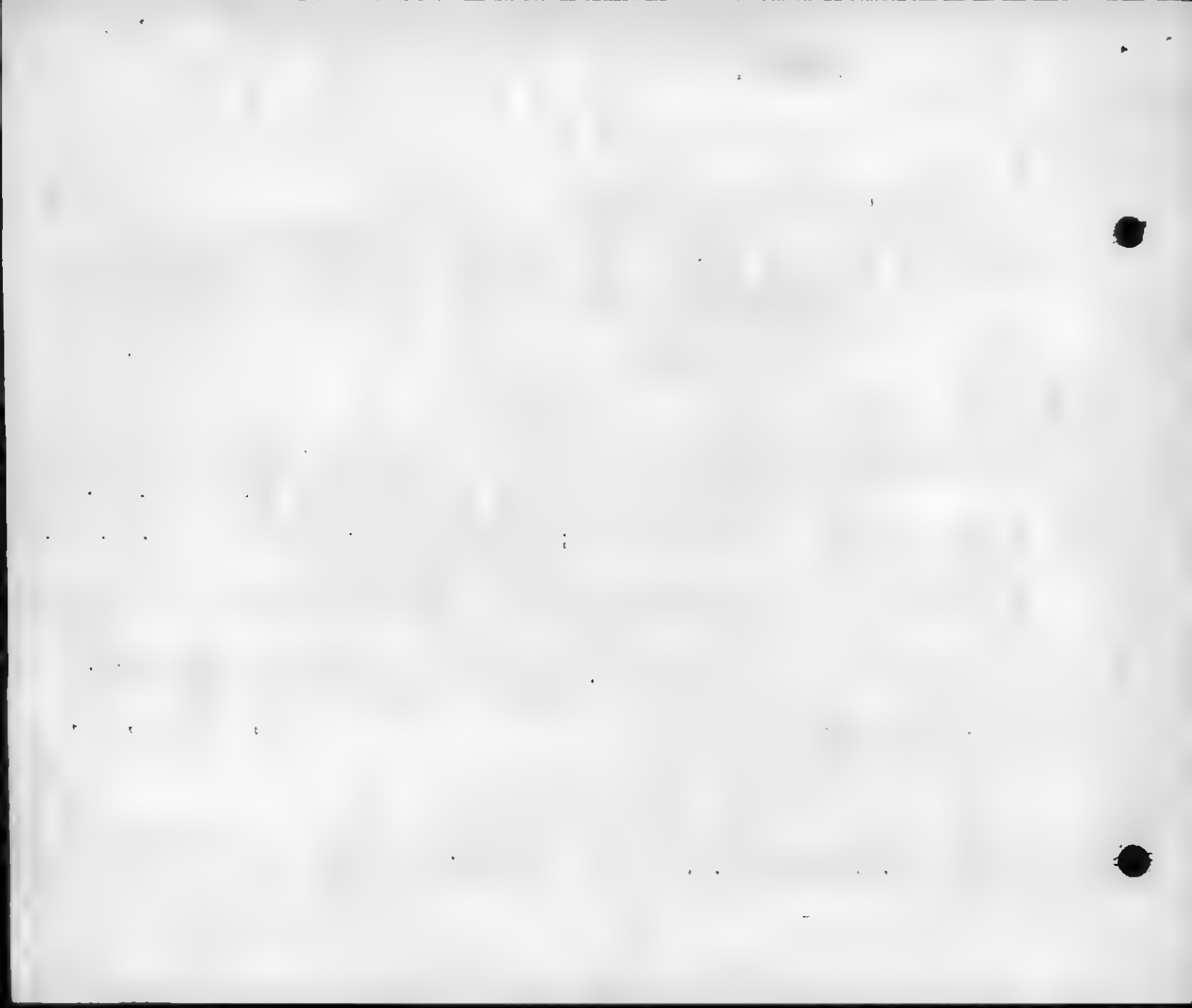
05677

5702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b> c. LENGTH OF STAY IN TB <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Physician's Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b> d. STREET ADDRESS <b>Rural</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Dorothy B. Harley</b>		4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 14, 1925</b>
9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Swann</b>		14. MOTHER'S MAIDEN NAME <b>Nora Proctor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Wilmer Harley, Waldorf, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema due to Renal Shutdown</b> DUE TO (b) <b>Thermal Burns; 85% second degree and 10% first degree</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <b>12 h.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Burning brush. Lighted kerosene caught dress afire</b>	
20c. TIME OF INJURY Month, Day, Year <b>7:15 p.m. 5-16 1960</b>	20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Waldorf, Charles, Md.</b> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>V.B. Dettor, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>V.B. Dettor, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-23-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Peters</b>		22d. LOCATION (City, town, or county) <b>Waldorf, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Maryland</b>		24a. REC'D BY REGISTRAR <b>May 21 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hunt</b>	

THIS CERTIFICATE IS VALID ONLY WHEN FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND. IF ANY DELAY IS NECESSARY, PLEASE EX-CEUTE THIS CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER'S OFFICE ALONG WITH FORM PM-3. PAGE 5 MAY BE RETAINED FOR YOUR FILES. FILE PAGES 1 AND 2 WITH THE REGISTRAR PRIOR TO BURIAL, CREMATION, OR REMOVAL.





## CERTIFICATE OF DEATH

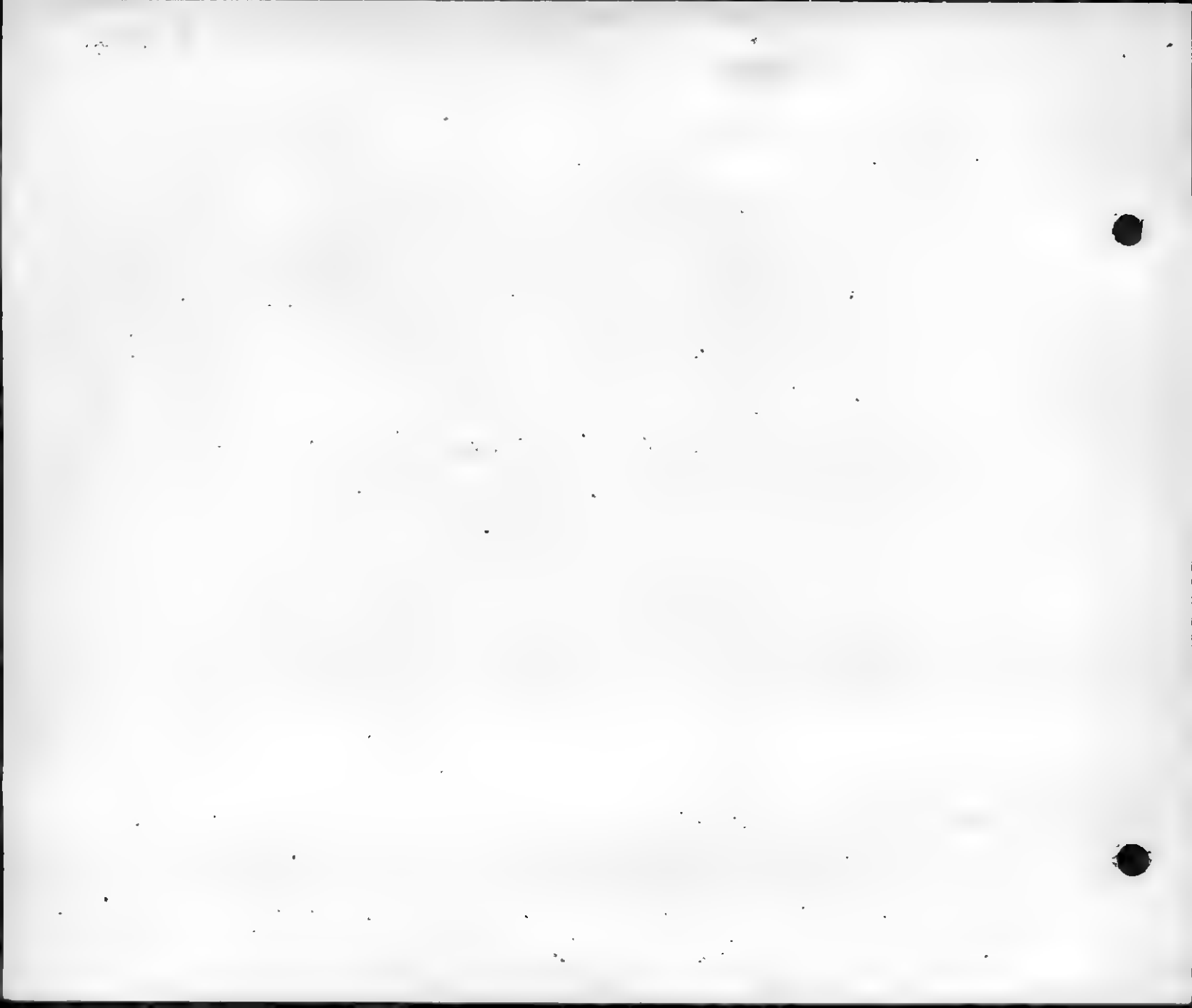
05678  
Reg. Dist. No.

5703

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAPLATA</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Indian Head, Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>				d. STREET ADDRESS <b>Rt #1 Box 2A</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Louise R Jones</b>				4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 Dec 1897</b>	9. AGE (In years last birthday) <b>62 yrs</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	IF UNDER 24 HRS Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Gov</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gov</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaiah Rofey</b>				14. MOTHER'S MAIDEN NAME <b>Sida Cox</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, specify unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>217-32-0268</b>		INFORMANT <b>Roger S Eement</b>		Address <b>Belmont, Va</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>14 May, 1960</b> to <b>27 May, 1960</b> , that I last saw the deceased alive on <b>26 May, 1960</b> , and that death occurred at <b>1:35 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>Arthur O. Woody, MD</b> M.D.				ADDRESS <b>JARWOOD CLINIC</b> DATE SIGNED <b>27 May 60</b>			
PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY</b>				ADDRESS <b>LAPLATA, MD</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-31-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Waldorf, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hunt Funeral Home, Waldorf, Md</b>				24a. REC'D BY REGISTRAR <b>DATE JUN 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. H. H. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05679

5704

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Welcome</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>POYNTON MAJOR</b>		d. STREET ADDRESS <b>1 POYNTON MAJOR</b>	
3. NAME OF DECEASED (Type or print) <b>SALVADORE WORTHINGTON KEMP</b>		4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 January 1893</b>
9. AGE (In years last birthday) <b>67 yrs</b>		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Simon J. Kemp</b>		14. MOTHER'S MAIDEN NAME <b>Kate Worthington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes.</b>	
INFORMANT <b>Mr. B.B. Kemp - Son, Welcome, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Now</b> , 19 <b>59</b> , to <b>6 May</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>6 May</b> , 19 <b>60</b> , and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>JARWOOD CLINIC</b> DATE SIGNED <b>6 May 60</b> ACTUAL SIGNATURE <b>Arthur O. Woody</b> M.D. <b>LA PLATA, MARYLAND</b> PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY</b>			
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 9, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Ignatius Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Chapel Point, Bel Alton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>AREHART FUNERAL HOME, INC. * LA PLATA, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>MAY 10 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

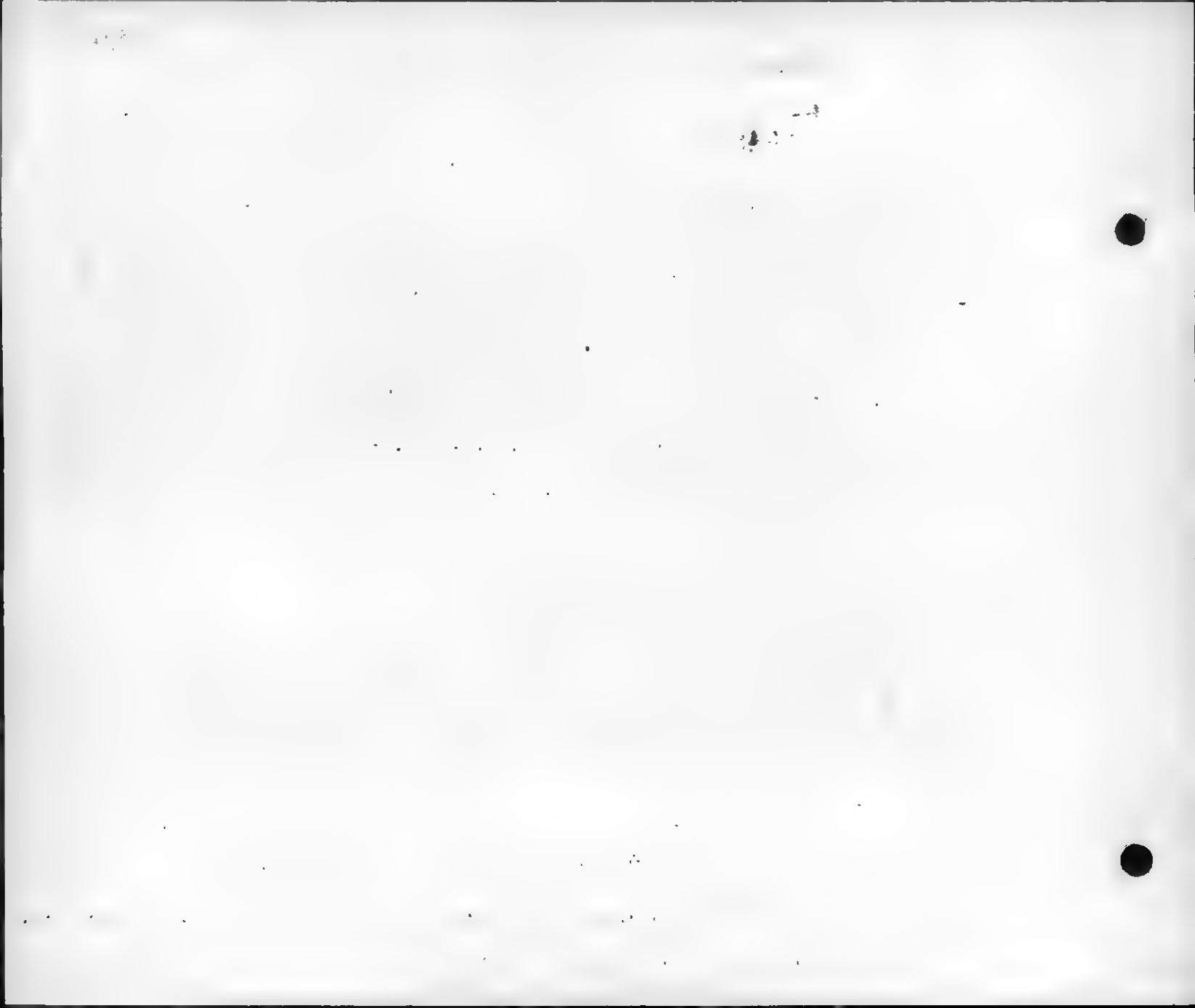
MEDICAL CERTIFICATION

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

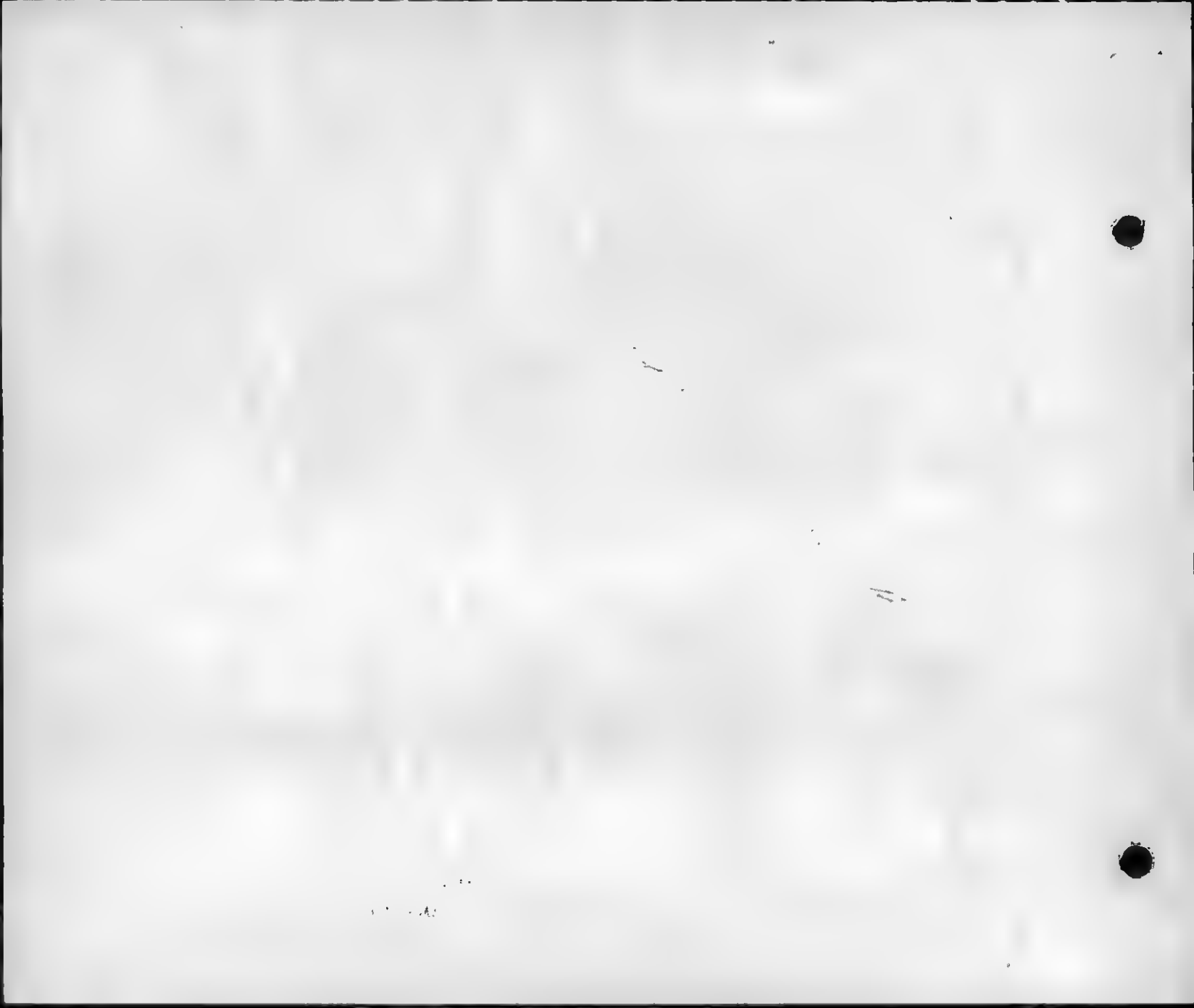
## 5705 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05680

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CHARLES</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POPE'S CREEK</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>POTOMAC RIVER</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>11522 Ind</u> b. COUNTY <u>NE260</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Y. and River</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>PAUL</u> First <u>FREDERICK</u> Middle <u>MURPHY</u> Last		<b>4. DATE OF DEATH</b> Month <u>5</u> Day <u>15</u> Year <u>1960</u>		<b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1-17-1925</u> <b>9. AGE</b> (In years last birthday) <u>35</u> yrs.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farming</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>James Winfield Murphy</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary M. Bridgett</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>Yes</u> <u>1943-1944</u> <b>16. SOCIAL SECURITY NO.</b> <u>216-18-5860</u> <b>17. INFORMANT</b> <u>Mrs. Edith Burch, Waldorf, Md.</u> Address		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Striking</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Striking</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3-15-60</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>BOAT OVER TURNED IN RIVER</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>5/15/1960</u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>RIVER (POTOMAC) (CREEK) CHARLES, MD.</u> (City or town) (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>E. J. Edrhen</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>5-20-60</u>			
<b>EXAMINER'S NAME (Type)</b> <u>E. J. Edrhen</u>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Buried</u>		<b>22b. DATE THEREOF</b> <u>5-21-60</u>		<b>22c. NAME OF CEMETERY, OR CREMATORY</b> <u>St. Peters</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Huntt Funeral Home, Waldorf, Md.</u>		<b>ADDRESS</b> <u>Waldorf, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE MAY 24 '60</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

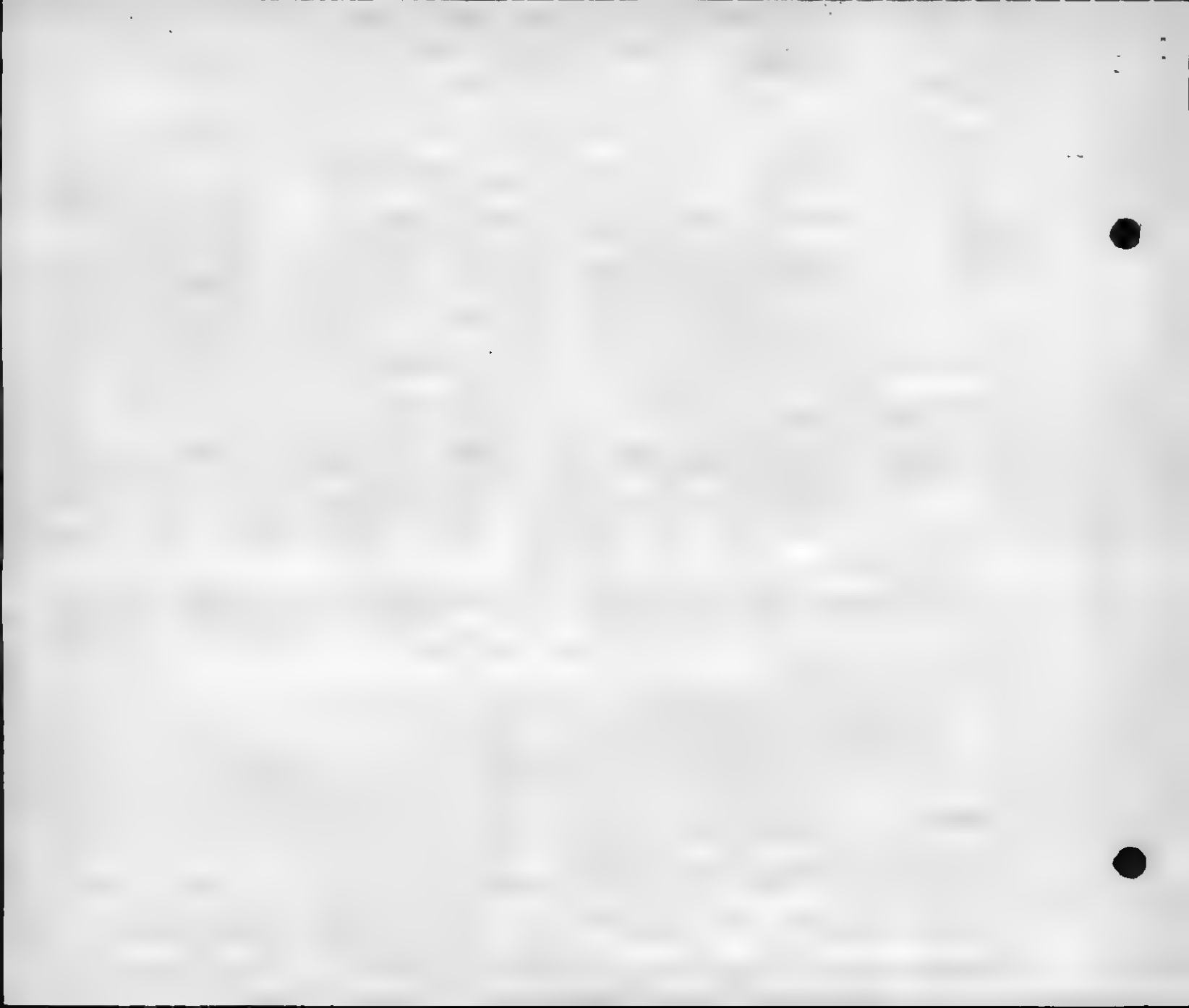
5706

## CERTIFICATE OF DEATH

Reg. Dist. No.

05681

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mdof</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 1121dof</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>STANLEY</u> Middle <u>Philip</u> Last <u>Philip</u>		4. DATE OF DEATH Month <u>5</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-90</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>South Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James S. Philip</u>		14. MOTHER'S MAIDEN NAME <u>UNK.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Inez Philip, 1121dof, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>GEN ART Sclerosis</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <u>HYPERTENSION</u> DUE TO <u>HYPERTENSION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5-11-60</u> <u>1952</u> <u>1951</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> to <u>5-11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>5-11-60</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. J. Edelen</u> M.D.		ADDRESS (Street, city or town, state) <u>5-12-60</u>	
PHYSICIAN'S NAME (Type) <u>E. J. EDELEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-16-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Philip Memorial Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Pt. Pierre, South Dakota</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dotson Funeral Home, Pierre, S. Dakota</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 16 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05682

Reg. Dist. No.

5707

1. PLACE OF DEATH a. COUNTY <u>Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physician Memorial Hosp</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>JAMES BUSTER SWANN</u>		4. DATE OF DEATH <u>MAY 6 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-1940</u>
9. AGE (In years last birthday) <u>20</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>James A. Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Lucille Swann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-38-5191</u>	
17. INFORMANT <u>Doris M. Swann, Waldorf, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock and Hemorrhage</u> DUE TO (b) <u>Crush Injuries of Chest</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 min.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Auto accident -- ran off road hit pole</u>	
20c. TIME OF INJURY Month, Day, Year <u>5-6 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, shop, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>La Plata, Charles, Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>V.B. Dettor</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V. B. DETTOR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5-6-60</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 10 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Peter's Cem</u>		22d. LOCATION (City, town, or county) <u>Waldorf, Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arnold Funeral Home, Waldorf Md</u>		24a. REC'D BY REGISTRAR <u>MAY 17 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Smith</u>			

18

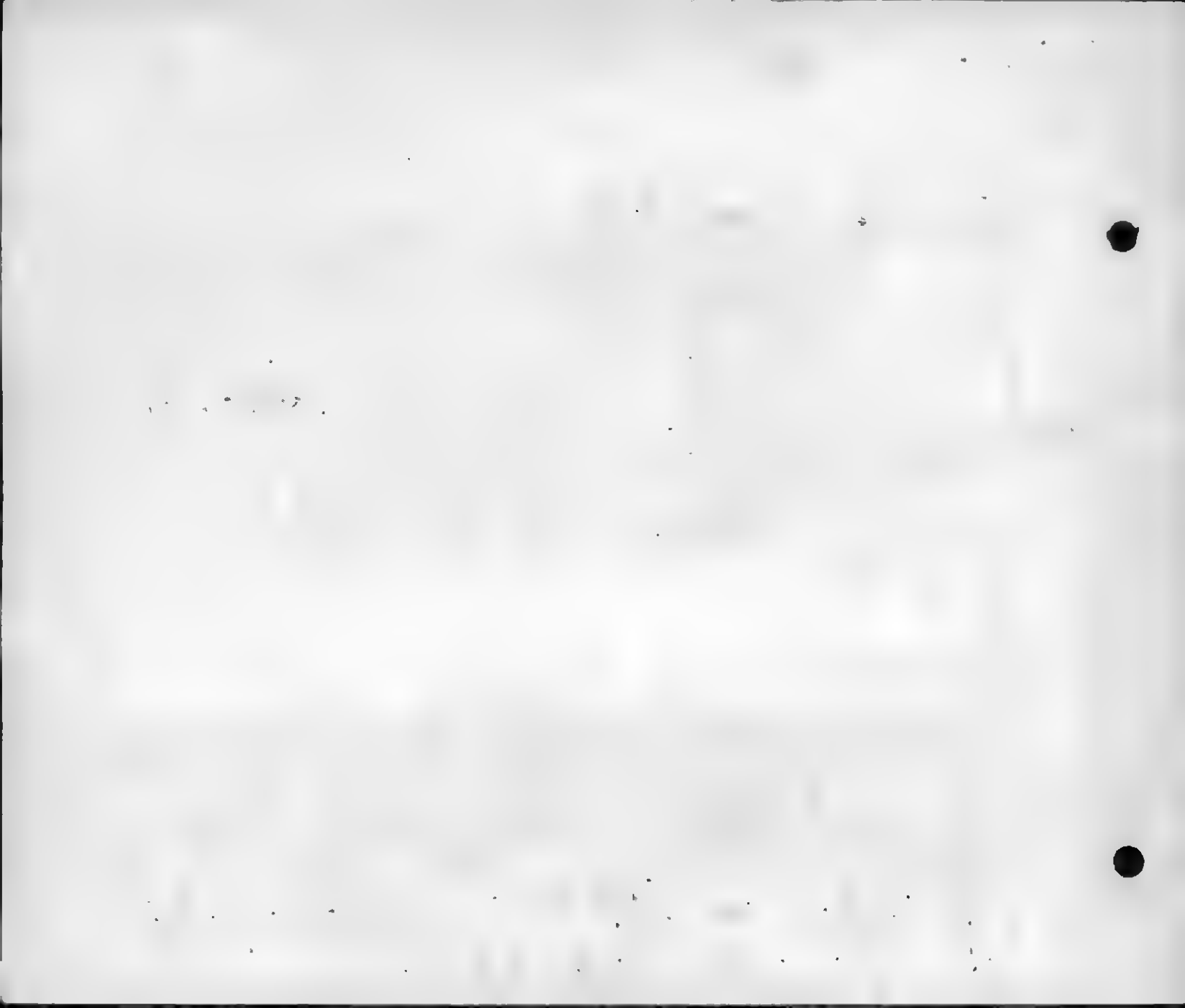
FOR STATE HEALTH DEPT.

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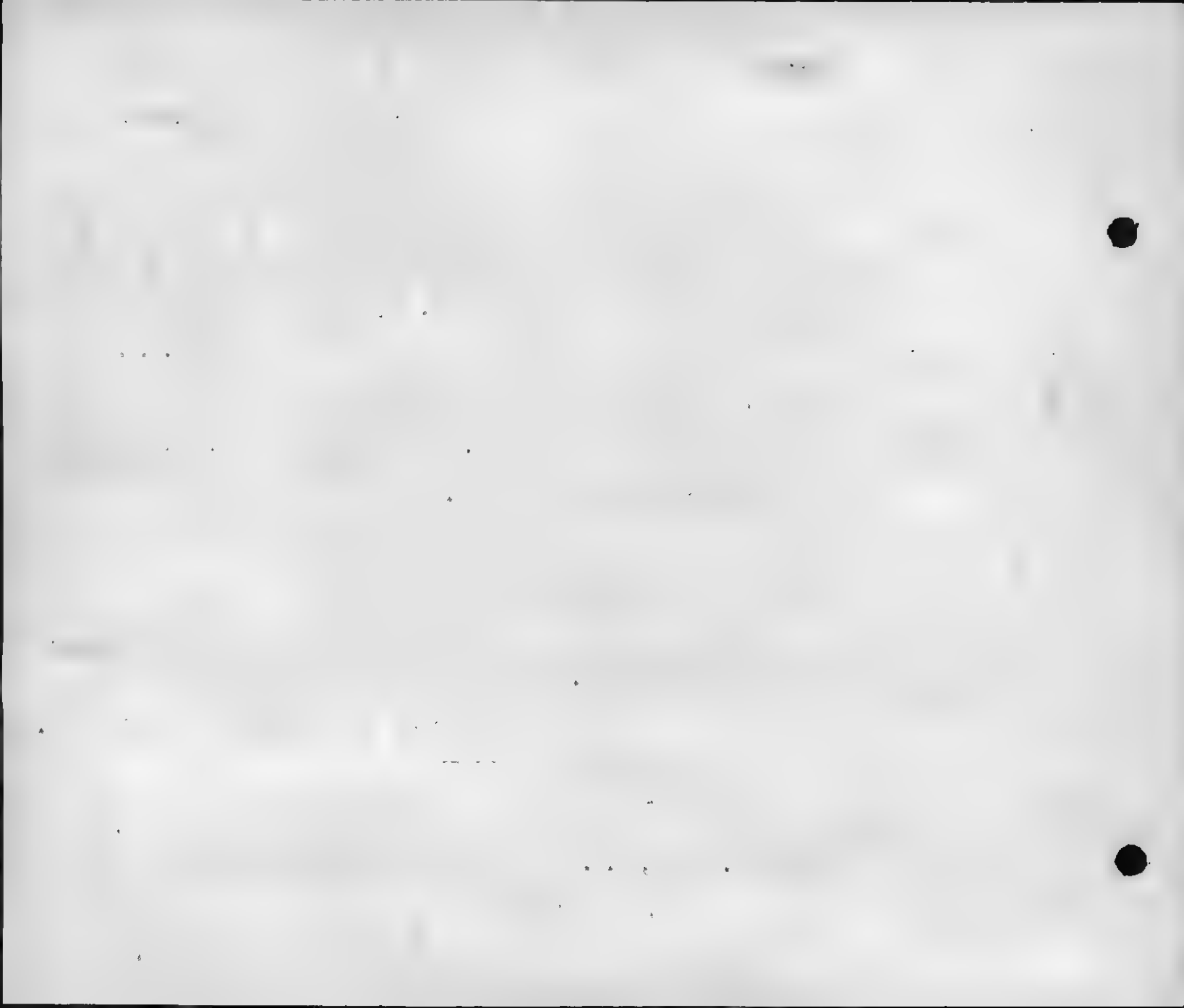
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15684

Reg. Dist. No.

5709

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head Md</b>			
c. LENGTH OF STAY IN 1b <b>1-Yr.</b>				d. STREET ADDRESS <b>General Delivery</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Bernard Joseph Viering</b>				4. DATE OF DEATH <b>5-18-60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W-US</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-1-1912</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe Fitter</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>	
13. FATHER'S NAME <b>Alons Viering</b>				14. MOTHER'S MAIDEN NAME <b>Eva Schriener</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>029-01-2738</b>			
17. INFORMANT <b>Dorothy Viering-(Wife)</b>				Address <b>General Dtl. Indian Head</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c) <b>Indefinite</b>							INTERVAL BETWEEN ONSET AND DEATH <b>14-Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Patient Had Pulmonary Tuberculosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>002X</b>					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>5-23-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
22d. LOCATION (City, town, or county) <b>Arlington, Va.</b>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home, Waldorf, Md.</b>				24a. REC'D BY REGISTRAR <b>MAY 23 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

**James E. Andrews**

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

**5-19-60**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WESTLAND STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2388

(M)

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

NAME: [Handwritten Name]  
AGE: [Handwritten Age]  
SEX: [Handwritten Sex]  
RACE: [Handwritten Race]  
DATE OF DEATH: [Handwritten Date]  
PLACE OF DEATH: [Handwritten Place]  
CAUSE OF DEATH: [Handwritten Cause]  
MANNER OF DEATH: [Handwritten Manner]  
SIGNATURE: [Handwritten Signature]  
DATE: [Handwritten Date]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hughesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>ANGELA DENISE WADE</u>		4. DATE OF DEATH <u>Month 5 Day 20 Year 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-60</u>
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR <u>3</u> Months <u>5</u> Days IF UNDER 24 HRS. <u>3</u> Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN ANDREW WADE</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA LOCKS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>John Andrew Wade, Hughesville, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>795.5</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bed</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>J. E. EDELEN</u>		DATE SIGNED <u>5-25-60</u>	
EXAMINER'S NAME (Type) <u>J. E. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-26-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST MARYS</u>	22d. LOCATION (City, town, or county) (State) <u>BRYANTOWN, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>THE HUNT FUNERAL HOME, WALDORF, MD</u>		24a. REC'D BY REGISTRAR <u>MAY 27 60</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thoma</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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ANY MEDICAL CERTIFICATE OF HEALTH—LAST MORE, 12  
MEDICAL EXAMINER'S CERTIFICATE OF HEALTH